STATEWIDE PROGRAM STANDING COMMITTEE
FOR ADULT MENTAL HEALTH

NOTES FOR MEETING OF
June 11, 2007

Members Present: Kitty Gallagher, Clare Munat, Sue Powers, Marty Roberts, and Jim Walsh

DMH Staff: Melinda Murtaugh, Jessica Oski, Frank Reed, Terry Rowe, and Beth Tanzman

Others: Richard Allain, Bob Bick, Anne Donahue, Sandi Knight, Mary Moulton, and Jeff Rothenberg

Clare Munat facilitated today's meeting.

Report on Vermont State Hospital (VSH): Terry Rowe

Department of Justice. Terry distributed a three-page list of document requests from the Department of Justice (DOJ) in preparation for the next DOJ site visit, scheduled for the week of June 25. (See the list, attached to these notes.) Any Standing Committee members who would like to see some of these reports for possible discussion at a future meeting should send their requests to Melinda Murtaugh for forwarding to Terry.

Questions and Answers. Anne Donahue asked questions about some of the policies and services at the Vermont State Hospital. Kitty Gallagher asked why activities have been moved to the hospital units. She also wanted to know why patients cannot go into the basement anymore to use computers and exercise equipment the way they used to be able to do. The purpose of relocating the activities, Terry replied, was to make more therapeutic services more accessible to more patients. Now, she added, the solution to one problem has created another one. She and the nursing staff are working on these issues to get back to patients' customary access to the Brooks activities area. Marty Roberts asked about meetings of the Treatment Review Committee. Terry said that it has not been meeting lately because of a vacancy for a nurse representative that must be filled to meet the full complement of membership. VSH is recruiting possible candidates. Marty stated her ongoing desire to be on the Curriculum Committee that VSH has in place. Richard Allain asked why patients are readmitted to VSH. A host of reasons, Terry responded.

New Patient Representative. Jerry Page is the new patient representative at VSH. He has been at work for a few weeks now.

Futures Update and Other Topics: Beth Tanzman

New Legislation on the Futures Project. Beth distributed copies of the statute that establishes the Advisory Council for Mental Health Services Transformation to succeed the Futures Advi-

sory Committee. Additionally, the new legislation clarifies the role of the Mental Health Oversight Committee.

The new advisory council membership, to be appointed by the Commissioner of Mental Health, is to include consumers and family members. The statute further provides that the Commissioner "shall coordinate and staff the council for the purpose of seeking input on mental health program options and policies . . ." Finally, the council "shall cease to exist on July 1, 2009." Beth asked Standing Committee members for their thoughts on the composition of the new council. Kitty Gallagher advised seeking members at the grass-roots level of organizations and advocacy groups. Time being short, Beth asked other Standing Committee members to get their ideas to her in the next couple of weeks.

The current Futures Advisory Committee will probably continue to meet until late summer, by which time the new advisory council on transformation should be formed. It is important, Beth said, not to have a break in input from consumers and families. Later on, Jim Walsh asked Beth to talk about the ways in which the work of the Futures Advisory Committee went well and ways in which it did not. Commenting that the question is a difficult one, she nevertheless offered the following observations:

- The Advisory Committee had a considerable investment in the planning process over the past three years (for example, in addition to the Advisory Committee proper, thirteen working subcommittees were—some still are—meeting regularly)
- The Advisory Committee sometimes tried to be directive rather than advisory
- Debates often centered on process rather than substantive issues
- High turnover in leadership positions and multiple layers of leadership and responsibility were difficult for everyone
- There were times that the state just did not take the Futures Advisory Committee's advice

It is very important now to find ways to strengthen consumer and family voices, Beth concluded, and to maintain staffing at a level that will make the new Advisory Council work.

Richard Allain asked what happens to patients who leave VSH to enter the Second Spring program and then refuse medications and become violent. Beth responded that it is critically important that Second Spring remain a voluntary program that will help people to recover and become members of the community again. The Second Spring Steering Committee was developed for transition-planning purposes. It brings together staff of Second Spring and VSH to explore and work through complex policy and program issues together.

Futures Project: Current Status. The Futures Project completed the first step of Vermont's two-step certificate-of-need process on April 12, when the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) approved a conceptual certificate of need (CON). The Conceptual CON focuses on replacing the inpatient functions of VSH.

The Governor's budget has essentially approved all community services proposed in the Futures Plan:

- ✓ Second Spring (now open in Williamstown)
- ✓ Six similar beds at another location, to be determined
- ✓ Six secure residential beds
- ✓ Ten additional crisis beds with implementation beginning in Fiscal Year 2007, and another six beds to be opened in Fiscal Year 2008
- ✓ Peer initiatives
- ✓ A care management system to assure appropriate levels of care throughout/along the continuum of services
- ✓ Alternatives to transportation by sheriffs for involuntary emergency examinations in inpatient settings

The funding for these new services will help to reduce the need for inpatient care and long-term rehabilitation at the State Hospital.

The policy preference for the future system adopted by the Futures Advisory Committee combines a broad array of community-based services with inpatient capacity located in conjunction with a medical facility. Inpatient services must be clinically appropriate and cost-effective. For the remaining inpatient capacity, Futures will look at four different configurations and evaluate operations, cost, and quality.

1. Option 1: One state-run hospital of fifty beds
2. Option 2: Three sixteen-bed hospitals (Fletcher Allen Health Care in Burlington, Retreat HealthCare in Brattleboro, and a state-run, stand-alone hospital in Waterbury), offering a total of forty-eight beds
3. Option 3: Primary program integrated with FAHC with a medium and smaller program (fifty beds). The specific distribution of beds between the Retreat and FAHC is still being developed.
4. Option 4: Primary program integrated with FAHC with two smaller capacities at Rutland Regional Medical Center (six beds) and Retreat HealthCare (four beds)

Standing Committee members expressed concerns and asked several questions about services, standards, and quality of care at RRMC. Beth acknowledged that RRMC has experienced a great deal of staff turnover recently but now seems on the verge of stabilizing its leadership team. RRMC has been invited to come to statewide forums this summer, she said. As for Central Vermont Medical Center, it simply has expressed no interest in doing more in the way of inpatient treatment.

The legislature has commissioned an independent study of Futures plans and options, Beth told Standing Committee members. The final report from the independent study is due November 1.

Technical Assistance Grants from the Substance Abuse and Mental Health Services Administration. SAMHSA is offering technical assistance in several areas of mental-health care and services to interested states. Possibilities include:

- ✪ Outcome-oriented state transformation
- ✪ Acute care services

- ✪ Co-occurring disorders (mental illness and substance abuse)
- ✪ Person-driven planning
- ✪ Peer specialist services
- ✪ Financing strategies
- ✪ Consumer inclusion and involvement
- ✪ Trauma-informed care
- ✪ Evidence-based practice implementation
- ✪ Core competencies for the mental-health work force

Vermont has an opportunity to ask for TA in between two and four of these areas, Beth told Standing Committee members. She asked for input from the Standing Committee members in the next couple of weeks, after which formal requests will be submitted to SAMHSA.

Proposal for Alternative Transportation: Bob Bick and Mary Moulton

HowardCenter and Washington County Mental Health Services (WCMHS) have designed a system of nonsecure transport for individuals being admitted involuntarily to psychiatric inpatient care for emergency examinations. The new system is intended for individuals screened as appropriate for the service as an alternative to the use of secure transport in these kinds of situations, Bob Bick, of HowardCenter, explained. WCMHS's Mary Moulton added that trained transport specialists would implement the protocol after screeners determine that a person could be safely transported in this manner. Additional transport options will include:

- ☙ Two trained transporters in an unmarked vehicle
- ☙ Trained transporter(s) in an ambulance
- ☙ Trained transporter(s) riding with family

Input from consumers and family members has been sought throughout the development of this proposal and will continue to be important as implementation goes forward. The agencies hope to have the new system in place in Chittenden, Washington, Addison, Franklin and Grand Isle, Lamoille, and Orange counties later this summer. The legislation guiding this change is 18 V.S.A. § 7511.

Bob and Mary will plan to return to the Standing Committee after the implementation of the new system to give a report on what is working well and what needs to be changed.

Advance Directives at the Vermont State Hospital: Jessica Oski

Jessica explained that advance directives are used most often to allow people to maintain control in times when they are incapacitated. "Capacity" is not the same as "person in need of treatment," she explained further. If a patient has an advance directive, VSH and other hospitals are bound to follow it. A Ulysses clause allows treatment to be administered over a person's refusal at the time treatment becomes necessary, but the clause must be in the advance directive.

A new law in 2005 established an online registry for advance directives in Vermont. People can go on line and at least post notice that they have an advance directive.

Jessica's work is primarily with the Futures Project. She welcomes additional questions that Standing Committee members may have.

Re-designation of the Clara Martin Center (CMC)

Jeff Rothenberg, Director of Community Rehabilitation and Treatment at CMC, joined the meeting for this discussion. He began by clarifying CMC's position on recovery and the importance the agency attaches to both the concept and the practice of individualized services to help consumers fulfill the goals that they set for themselves.

Kitty Gallagher asked Jeff for more information about CMC's emergency apartment. Jeff explained that it is for people who would be in the hospital otherwise. It is not a staffed apartment, he clarified.

Clare asked how many people are on the Local Program Standing Committee. Jeff replied that the attendance varies from meeting to meeting. Generally, five members are from Bradford and ten are from Randolph. They have different issues (space in Bradford and the consumer drop-in center evenings and weekends in Randolph).

Another question from Clare: How does the agency involve family members? Jeff replied that CMC had family psychoeducation some years ago in Bradford, but the group that was organized in Randolph has stopped meeting. Family groups currently meet in White River Junction and Berlin. CMC would like to increase the family supports that it gives, Jeff said.

The agency has a consumer newsletter, and thought is being given to having one for families too. CMC has applied for a grant for a drop-in center; consumers are involved in its development. Consumers are also involved in treatment planning. The most recent minimum standards review found a need for greater clinical interpretation of consumer-stated goals.

Jeff described the Safe Haven project in Randolph. Safe Haven is a collaboration of the Clara Martin Center, Vermont Psychiatric Survivors (VPS), and the National Alliance on Mental Illness of Vermont (NAMI—VT). It has six beds for individual clients and serves Washington, Windsor, and Orange counties. The majority of funding for the project comes from a grant from the Department of Housing and Urban Development. Two staff are CMC employees, and there is a case manager as well. Peer mentors work after hours and on weekends; they are VPS employees. Safe Haven has some similarities to a group home. It is a completely voluntary program. Clients on orders of nonhospitalization sign agreements that they will engage in services. The average stay is probably between six and nine months.

When the state first received a grant for training in co-occurring disorders, the Clara Martin Center decided to adopt the model for all programs and not just for Community Rehabilitation and Treatment, Jeff told Standing Committee members. The agency's staff went through a tremendous amount of training in the second year of the grant. The trainings continue; they are

given twice a year for all new employees. CMC has the highest proportion of clients with dual diagnoses of any designated agency in the state. Dual-diagnosis groups have formed in both Randolph and Bradford, and there is one for women only in Randolph.

Washington County Mental Health triages CMC's emergency calls and the system works well, Jeff said. The decision has been made not to rehire an Emergency Coordinator for Orange County, at least not right away. Jeff provides clinical supervision for two full-time-equivalent (FTE) Emergency Services workers.

Two new projects the agency has taken on recently are developing a new space for a drop-in center and hiring consumers as support workers. In response to a question from Clare, Jeff said that he did not know offhand what CMC's staff turnover looks like, but the clinical leadership has been stable for several years (for example, the nurse practitioner in Randolph has been there for twelve years). A new JOBS (**J**ump **o**n **B**oard for **S**uccess) employment program for youths of transitional age will be starting in Randolph soon.

The Standing Committee voted unanimously to recommend that the Commissioner re-designate the Clara Martin Center without any conditions attached.

Approval of May 14 Notes

Notes on the Standing Committee meeting of May 14 were unanimously approved as written.

Public Comment

Anne Donahue had several updates for the Standing Committee. Members who want more information should get in touch with her.

- **Transportation.** Anne thought that the topic on today's agenda was about the Division of Mental Health's recent report on transport of adults for inpatient hospitalization and not, as happened today, about a new proposal for other transportation arrangements as alternatives to the use of sheriffs for secure transport of individuals being involuntarily hospitalized for emergency psychiatric examinations. She has several comments regarding the report when the committee takes up that discussion.
- **Futures Project.** Anne has additional information from her perspective on the Futures Advisory Group and its abolition but she did not take the time today to go into it as it was already nearly 4:30 in the afternoon when she spoke. (The Public Comment portion of the meeting was scheduled for 3:00-3:30, but Anne deferred to discussion at that time of the re-designation of the Clara Martin Center. In any case, Standing Committee members have not been strict about adhering formally to the Public Comment period to hear comments from others who attend these meetings, so that Anne had several opportunities earlier to speak on various topics and did so.)
- **Rutland Regional Medical Center.** On the recent turnover of Medical Directors at Rutland Regional Medical Center, Anne offered her viewpoint that RRMC Medical Directors have left because they were blocked when they tried to make changes.

- **Second Spring Advisory Committee.** Anyone interested in being on this Advisory Committee should contact Roy Riddle.
- **Chief Justice's Task Force.** The work of this group involves reviewing the policy implications of possible changes in the interrelationships of Mental Health, Corrections, and Juvenile Justice. Some of the branches of state government are involved, Anne said, but mental-health consumers and advocates are absent except for representation from the National Alliance on Mental Illness of Vermont (NAMI—VT) and so are community mental health centers.
- **Proposed Lifetime Ban on Possession of Weapons by People with Mental-Health Issues.** Anne sees major implications for recovery and stigma issues.
- **Medicaid and DRG (Diagnosis-Related Grouping) in Vermont.** Medicaid is working toward a DRG system in Vermont, which would be devastating to the inpatient system of care, Anne said. This is an advocacy issue that needs further discussion, she concluded.

Report from the Membership Subcommittee

The Membership Subcommittee sees a need for further recruitment of a provider now that David Mitchell has left the Standing Committee. Additional recruitment efforts need to be directed toward consumers and families. Marty volunteered to bring up the subject at a meeting of the Peer Initiative Work Group later this week. Clare offered to check with the Local Program Standing Committee for United Counseling Services in Bennington. Jeff offered to explore interest in Orange County and among CRT Directors.

Topics for the July 30 Agenda

- Introductions, approval of notes, reviewing agenda
- System of Care Plan for Fiscal Years 2008-2010
- VSH Report: Topics to be selected from DOJ request for documents
- DMH Transportation Report
- Updates from Marty on peer support work group and peer initiatives
- Clarification of roles of Standing Committee and Commissioner's Advisory Council on Mental Health Transformation

Important Note for July 30 Meeting

The Standing Committee's meeting on July 30 will begin at 10:30 a.m. and conclude at 1:30 p.m. Lunch will be provided.

Meeting of Vermont's Mental Health Block Grant Planning Council

The Planning Council will meet on the afternoon of July 30 from 2:00 until 4:00, also in Stanley Hall, Room 100. The major purpose of the meeting is to review Vermont's block grant application for Fiscal Year 2008 and to formulate a response for the Center for Mental Health Services.

DOCUMENTS REQUESTED BY THE DEPARTMENT OF JUSTICE

Distributed at the meeting of the Statewide Program Standing Committee for Adult Mental Health on June 11, 2007

Comprehensive Therapeutic Treatment plan: one per Treatment Team--last one completed and one per Treatment Team--one with at least two reviews
Behavioral Treatment Plans: copy of all plans initiated in 2007; copy of all training in this area 2007
Initial Assessments (all disciplines) for all admissions May 2007; document specifying what is required in psych assessment
Policy and Procedure: all written or revise 2007
Patient schedule: copy of each patients' schedule for all current inpatients
Psychosocial treatment: copy of any program description developed in 2007; list of all groups currently offered; copy of form used by group leaders to communicate observations/findings to Treatment Team
Psychopharm: list of all patients with current psychiatric meds; description of how polypharmacy is monitored; current policy on PRN psych meds
Diagnosis: list of all patients with Axis I-III diagnoses
Any 5 Annual Psychiatric Assessments done in 2007
Any 5 Psychology Assessments that include formal testing done in 2007
Any 5 Comprehensive Rehab Assessments done in 2007
List of all patients discharged in 2007 with admission and discharge dates, discharge site, whether readmitted to VSH
Aftercare plans for all patients discharged in 2007

List of all patients put on PPV's May 2007 with outcomes for each
Status report on 6 nursing home patients identified in our Feb 2007 report
Status report on each patient currently at VSH who is a chronic med refuse (greater than one month); plans to address each patient's med refusal
List of last 5 patients referred for ECT and date of referral and whether treatment was done
Substance Abuse--list of specific services for SA patients
Pharmacy--copy of any 5 recommendations from pharmacist to psychiatrist
Environment: list of all environmental improvements in 2007
Safety report for 2007
Abuse/neglect database for 2007
Last ten completed Abuse/neglect Investigations
All incident reports for 2007 that involved injuries, major or minor, to patients and/or staff
Minutes of all meetings of the Incident/Quality/Risk Management Committees in 2007
Current Abuse/Neglect Reporting Policy
Current Risk Management Policy
Records of all performance improvement projects/committee meetings in 2007
List of all patients requiring seclusion/restraints in 2007
Minutes of all meetings of the Pharmacy and Therapeutics Committee in 2007
Current Adverse Drug Reaction (ADR) Policy and any guidelines
All ADR aggregated data and data analysis in 2007

Last ten completed ADR forms/data collection tools
Current Medication Variance (Error) Reporting (MVR) Policy and any guidelines
ALL MVR aggregated data and data analysis in 2007
Last ten completed MVR forms/data collection tools
Any Intensive Case Analysis/Sentinel Event reviews related to ADRs or MVR in 2007
Minutes of all meetings of the Mortality/Morbidity Review Committee meetings in 2007
List of all patient transfers to local emergency rooms/hospitals in 2007, including dates, names and reason for transfer.